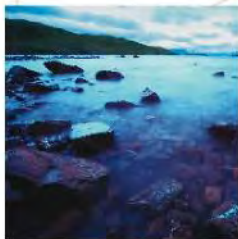




DEVELOPING CULTURALLY RESPONSIVE SERVICES FOR WORKING WITH REFUGEE YOUTH WITH MENTAL HEALTH CONCERNS



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Report prepared by:

Dr Amritha Sobrun-Maharaj

Dr Shoba Nayar

Ms Chaykham Choummanivong

On behalf of:

Auckland UniServices Ltd

Private Bag 92019

Auckland

New Zealand

For:

Te Pou

PO Box 108 -244

Auckland

New Zealand

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CONFLICT OF INTEREST STATEMENT

The project investigators declare no conflict of interests to this research project.

DISCLAIMER

This report summarises key findings on the topic of refugee youth experience of mental health services in New Zealand. All care has been taken to accurately capture and interpret the perspectives of research participants, while maintaining their privacy and confidentiality. Any views or opinions expressed in the report are those of the authors and do not necessarily represent the views of Te Pou.

EXECUTIVE SUMMARY

To date, few studies have examined the mental health needs of, prevalence of mental illness among, and use of child and adolescent mental health services by refugee youth and their families living in New Zealand.

Previous research has identified that refugee youth are at considerable risk of developing mental illnesses and experiencing co-morbid disorders, such as depression and anxiety (Pumariega, Rothe, & Pumariega, 2005; Schweitzer, Melville, Steel, & Lacherez, 2006). Increased risk of mental illnesses for refugee youth is due to a number of factors:

- pre-migration experiences, including: war, physical and sexual injury, family separation, refugee camp life with its daily struggle for survival, disempowerment and decreased safety, violence and atrocities, extreme poverty and deprivation
- immigration and re-settlement experiences, including: cultural differences, limited language abilities, lack of social supports, new sets of behaviours and expectations, and abandonment of one's home land
- adolescent developmental challenges, including: adjusting to ongoing life stressors, maintaining the family system, negotiating educational systems, and manoeuvring through impersonal social and health service systems.

Due to the elevated risk of mental illness, and a complex assortment of risk factors and cultural beliefs about mental health and help-seeking, the mental health needs of refugee youth have specific implications for mental health services in New Zealand.

RESEARCH OBJECTIVE

The key objective of this research was to examine issues and challenges faced by refugee youth who are presenting to mental health services in New Zealand with a view to better meeting the needs of this population through informing service improvement. These services include general practices, school guidance counsellors and community mental health services.

METHOD

This study involved two phases. The first phase consisted of nine focus group interviews. Four focus groups, involving 20 mental health and community professionals from the greater Auckland region, explored the professionals' experience of working with refugee youth. A further five focus groups considered the experiences of 20 refugee youths, and their caregivers or parents, who are currently accessing or have previously accessed mental health services within New Zealand. In the second phase, 16 additional youth respondents participated in individual interviews to develop in-depth information on these individuals' experiences.

FINDINGS

Youth, their families, and mental health and community professionals identified a range of issues and challenges faced by refugee youth and their families in accessing mental health services in New Zealand. These issues and challenges are grouped into four categories.

1. Personal and cultural – refugee youth encounter challenges related to pre-migration trauma, post-migration and settlement challenges, discrimination, adolescent development, challenges in lifestyle, confidence, dignity and homesickness.
2. Family – family situations are often complex, and these complexities are closely connected to the wellbeing of refugee youth. Working with these complex situations may pose a challenge for mental health professionals, but this is necessary for effective interventions. Furthermore, the family's mental health beliefs and knowledge can have an impact on the help-seeking behaviour of refugee youth.
3. Social and economic – barriers to accessing mental health services include the times of day that services are open, issues to do with transportation and waiting lists.
4. Service capability – services face challenges, such as managing interpreters' and support people's responses, and liaising with other agencies. Cultural support workers and training were recommended to assist services to address gaps in mental health professionals' cultural knowledge and skills.

RECOMMENDATIONS FOR SERVICE DEVELOPMENT AND IMPLEMENTATION

To address the complexity of issues facing refugee youth and their families, mental health services should aim to:

- improve the cultural capacity of their workforce through training or involvement of multi-ethnic teams, including cultural support workers
- consider local beliefs in their choice and implementation of interventions
- build community engagement and interagency collaboration, particularly with school and primary care services.

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PART ONE: INTRODUCTION AND BACKGROUND

The United Nations High Commissioner for Refugees (2009) has reported that there are currently 31.7 million refugees worldwide, in more than 110 countries. Between 1998 and 2007, over 3,700 refugee youth were granted residency status in New Zealand (Department of Labour, 2009). International research suggests that refugee experiences are associated with an increased risk of mental health concerns (Keyes, 2000; Pumariaga et al., 2005), and thus that this group is an important at risk group that needs to be considered in services. There has been limited research to date, in New Zealand and overseas, about the mental health needs and adjustments of these youth and their families (Ho, Au, Bedford, & Cooper, 2002). In particular, few studies carried out with refugee youth and their families have examined their mental health needs or their use of child and adolescent mental health services. There is also an increasing need for services and clinicians to understand and meet the needs of this group.

RESEARCH AIMS

The main question asked in this project was: what is the nature of the issues and challenges faced by refugee youth when using mental health services in New Zealand?

There were two key aims.

- 1) To provide information about refugee youth's experience of mental health services in New Zealand, including investigating the psychological needs of refugee youth who have accessed, or are currently accessing, mental health services, as well as exploring the work undertaken by services to meet these needs.
- 2) To inform the implementation of *Te Tāhuhu: Improving Mental Health 2005–2015* through helping to “build responsive services for people who are severely affected by mental illness and/or addiction – with immediate emphasis on improving the responsiveness of services” (Minister of Health, 2005, p. 11) for refugee and migrant communities.

REFUGEE YOUTH AND MENTAL HEALTH NEEDS

Research related to refugee youth and mental health has identified pre-migration (Keyes, 2000) and post-migration settlement challenges (Ho et al., 2002) as key stressors for refugee youth and their families. Indeed, the Working with Muslim Communities in New Zealand Conference (2004) report stated that trauma (resulting from civil war experiences and living in refugee camps), isolation from family and friends, and unemployment have an adverse effect on the mental health and wellbeing of refugees. Further, developmental challenges potentially intensify mental health issues. Coping with puberty and physical changes to the body, engaging in critical phases of identity formation, and managing hormonal changes, in addition to adapting to living in a new environment, can place additional stress on refugee youth. This in turn increases their risk of developing psychological problems, or functional difficulties in managing everyday life (Westermeyer, 1991).

In addition to the above challenges, schooling and coping, or not being able to meet the demands of the curriculum, are issues facing some refugee youth. Outcomes of not coping with the school curriculum include a growing awareness of individual struggle, and the experience of frustration and embarrassment. This can negatively exacerbate refugee youth's endurance, when their functioning capacity may already be impaired as a result of other stressors in their life and diminished positive coping mechanisms. Navigating cultural difference, discrimination, fear and isolation, including significant loss of lifestyle, confidence and dignity, and adjusting to language differences, are just some of the factors that must be managed (Hodes, 2000; Davies & Webb, 2000). These findings, in particular that of discrimination and language acquisition difficulties, are supported by the New Zealand Immigration Service's (2004) investigation into refugee resettlement. When discrimination is experienced from the host community, or from professionals, Raval (2005) found that families had less confidence in healthcare providers and more ambivalence about using services.

For refugee youth, a critical challenge in the process of adjusting to living in a new environment relates to bridging the widening gap between new beliefs, norms and behaviours, and their family's traditional beliefs, norms and behaviours. For instance, Elliot, Lee and Jane (1995) found that children and youth are frequently used as interpreters and cultural brokers in medical, school and other settings. In such circumstances, the conditions or stressors affecting the youth can increase, which has the potential of perpetuating acculturative or psychological stress for the whole family.

As predicted by the factors discussed, previous research has identified that refugee youth are at risk, if not at greater risk than migrants, of developing mental illnesses and experiencing co-morbid disorders, such as depression (Pumariaga et al., 2005) and anxiety (Schweitzer et al., 2006). Keyes (2000) agreed that variables such as pre-migration stress, experience of trauma and post-migration stress are highly correlated with the development and maintenance of mental illness within refugee groups. Accordingly, refugee youth mental health needs have specific implications for the fields of psychology and mental health in New Zealand.

MENTAL HEALTH SERVICES FOR REFUGEE YOUTH

Anecdotally, refugee youth are believed to be under-utilising mental health services, relative to their potential need for these services. A number of reasons have been suggested to explain under-utilisation. One reason relates to parent or caregiver attitudes towards psychological problems and treatment. In many cases, carers will have their own culturally defined understanding of impairment or distress, and thus refuse to accept conventional Western methods of psychological intervention (Hodes, 2000).

Additionally, because caregivers may themselves be experiencing emotional distress, they may not recognise psychological or behavioural distress in children (Sack, Angell, Kinzie, & Rath, 1986). Practical and structural factors, such as lack of fluency in English, limited awareness of available services and difficulty in registering with general practitioners (GPs),

may also serve as barriers to referral and attendance at child and adolescent mental health clinics (Hodes, 2000).

International research has found that mental health services for refugee youth are often unavailable in their native language, and not congruent with their culture and values (Geltman, Augustyn, Barnett, Klass, & Groves, 2000). This has a number of implications.

Firstly, at the primary health level and at school, there might not be sufficient time, specialist skills and knowledge to address the range of mental health conditions that services encounter. This increases the risk of exacerbated mental health problems or early symptoms.

Secondly, the youth and family may access the mental health service under involuntary conditions, and the service received at a crisis level may not be a positive experience for families. This subsequently feeds into a vicious cycle of reinforcing and maintaining negative attitudes about mental health services held by refugee youth and their families.

Thirdly, therapists in Western countries are rarely able to communicate in languages spoken by refugees and asylum seekers living in their countries (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Languages are not directly interchangeable; meanings may be coded, emotionally processed and internalised in one language, and may not always be directly accessible in another (Keefe, 2008). Mind (2005) states that cultural and religious practices, including language differences, have been widely identified as barriers to accessing mental health services. Not having enough interpreters, or working with interpreters not skilled in working within the mental health field, can lead to low referral rates for therapy, including incidences of misdiagnosis (Tabassum, Macaskill, & Ahmad, 2000). Furthermore, refugees' experiences of discrimination from the host community, or from professionals holding similar prejudicial attitudes, can result in less confidence in health care providers and more ambivalence about using services (Raval, 2005).

In recognition of these challenges for mental health service providers, a number of innovative approaches to service provision for young refugees have been piloted in the United Kingdom (Hodes, 2000). One innovation was the development of specialised mental health projects for young refugees and their families, which provided pathways to care outside the normal referral system. Those providers in favour of specialist refugee services highlighted the limitations of generic outpatient mental health teams, which were found to operate without particular expertise in addressing cultural or migration issues (Davies & Webb, 2000). Birman et al. (2005) suggested that for young refugees and families to gain optimum benefit from specific evidence-based psychological interventions, clinicians must further address the context of acculturation and resettlement within families, schools and other settings of relevance to refugee children. For this to occur, Ehntholt and Yule (2006) stipulate a comprehensive model of service provision, in which case management, psycho-education, and the integration of culturally-appropriate concepts of distress and recovery become critical components of care, in addition to psychotherapy.

In an effort to gather practice-based evidence from existing mental health services for refugees, Birman et al. (2008) conducted a collaborative study of International Family, Adult, and Child Enhancement Services, a comprehensive, client-centred community-based outreach mental health programme working with refugee children and their families. The study looked at the programme participants and service delivery model, including assessing whether participants improved over time as a function of services. These services included a multidisciplinary team of psychotherapists, art, occupational and dance therapists, psychiatrists and ethnic mental health workers, who provided cultural and linguistic competence, and worked as part of a mental health team. In addition, flexible services were provided at locations most comfortable to programme participants, including home, school, office and other community locations. Results showed that this multimodal flexible delivery contributed to participant improvement.

While improving access to care is a key element in addressing the mental health needs of young refugees, Ehntholt and Yule (2006) posited that these needs will remain unmet without the provision of evidence-based treatments focused on specific psychological problems and associated social impairment. Given the current lack of literature on clinical effectiveness in refugee mental health, clinicians must rely on careful case planning and formulation in order to successfully engage with clients and deliver culturally and developmentally appropriate interventions (Grey & Young, 2008). It is, therefore, important that health professionals working with refugee youth are aware of the pre- and post-migration experiences. This should include knowledge of those psychological risk factors that are especially relevant for refugee youth, such as traumatic loss and social isolation. Attention should also be given to identifying and strengthening individual and systemic factors that promote psychological resilience.

SERVICE DELIVERY AND USE IN NEW ZEALAND

In 2003, Action for Children and Youth Aotearoa identified that, for refugee children and young people in New Zealand, there was no specialist service that focused on supporting the young person's physical and psychological recovery and social integration. There are, however, mental health services, ranging from school counsellors within secondary schools, to GPs at the primary health level, to child and adolescent mental health services within the community. Each of these services has different roles and functions, with respect to supporting the recovery of refugee youth who are experiencing mental health problems.

A challenge for services in New Zealand is the diverse and dynamic nature of the refugee population that needs to be accommodated in designing mental health services and programmes. Birman et al. (2005) contended that it is not enough to simply design ethnic-specific programmes, and the Ministry of Youth Development (2005) identified that services for refugee youth need to be holistic in their design and delivery. Being holistic involves considering the demands and pressures on the family as a whole, in addition to the issues presented by the youth.

In one of the few studies conducted with refugee populations within New Zealand, with regard to service delivery and refugee use of psychiatric services, Guerin, Guerin, Diiriye and Yates (2004) found that Somali conceptions and expectations about mental health disorder and services were influenced by their cultural and religious beliefs. Further, some participants reported that the direct cause of why they might need mental health service input, or were experiencing difficulties, was a preoccupation with family reunification or other resettlement stressors. Causes were not necessarily the result of the experience of trauma. Guerin et al. (2004) argued that difficulties with translation, miscommunication, inadequate cultural skills and knowledge were some of the problems that prevented adequate treatment with the Somali population.

More recently, Thorburn, David, Hagi and Jackson (2009) completed an evaluation of the Refugees as Survivors New Zealand Auckland regional refugee mobile mental health team, which was developed as a pilot to service refugees with mental health needs. The evaluation revealed that easy access to the service was important, and having refugee community link workers as part of the core team was a strength. These community workers not only shared cultural similarities, but they had also experienced similar challenges on resettling, and had a wide knowledge of the services available in various communities. Furthermore, the community workers were able to assist the team to provide a holistic approach, because of their contacts with the wider community. Additionally, the team's therapeutic diversity helped different clients to be assisted and supported in a variety of ways.

Currently in New Zealand, there is no record of the prevalence of refugee youth accessing mental health services at the primary and secondary health level, and at the education level. This, compounded by a lack of knowledge of the ethnic or cultural background to which refugee youth belong, has implications for the development of cultural competency within the workforce. Furthermore, there is a lack of formal data about the aetiology or reasons for refugee youth accessing the service, about what services were completed with the youth, or the reasons for their exiting the service, for example failure to engage or treatment

completion. This knowledge would provide a sound foundation to help develop a service to engage and work more effectively with refugee youth and their families.

At present New Zealand only has two designated refugee mental health services, one operating in Auckland and the other in Wellington:

- Refugee as Survivors Auckland, which recently launched the Refugee Youth Action Network that provides culturally responsive counselling and guidance to refugee youth. This service also includes a regional mobile health team, which employs community link workers to bridge some of the cultural gaps.
- Wellington Refugee as Survivors Trust, which provides mental health services and helps refugees to resettle in New Zealand.

The majority of services, such as adolescent mental health services, are integrated into mainstream community health services. As a result, a lack of services available in refugee youth's native languages and different understandings of mental health are just two of the barriers that limit refugee youth accessing such services. However, international research has shown that services that are flexible in location and time, and respond to refugee people's needs, can enhance participation.

PART ONE: SUMMARY

Part one of this report introduced the study and provided background information that places the study in context, including a review of mental health needs of refugee youth, and the provision of mental health services both internationally and in New Zealand. As an important at risk group, it is vital that responsive services are built for youth severely affected by mental illness or addiction. To facilitate that process, the experiences of refugee youth must first be understood. Therefore, this project asks the question: what is the nature of the issues and challenges faced by refugee youth when using mental health services in New Zealand?

For many refugee youth, their mental health is compounded by issues such as pre-migration trauma, isolation from friends and family, unemployment, poor integration with schooling, and a cultural divide between traditional and New Zealand beliefs, norms and behaviours.

PART TWO: ISSUES AND CHALLENGES FACED BY REFUGEE YOUTH PRESENTING TO MENTAL HEALTH SERVICES IN NEW ZEALAND

This section presents the findings from the focus groups and individual interviews, concerning the issues and challenges faced by refugee youth presenting to mental health services in New Zealand.

The findings presented in this report were obtained from two sources. The first source consisted of two sets of focus groups. The first group was made up of mental health and community professionals from the greater Auckland region working within the refugee community. Refugee youth and their caregivers or parents made up the second focus group. Further information was collected through individual face-to-face interviews with 16 refugee youth.

An explanation of the research design and methods for collecting and analysing this data can be found in Appendix A. The information obtained in the focus groups and individual interviews pertained to factors influencing mental health needs, challenges with accessing mental health services, and potential actions for improving service access and delivery.

Part two of this report consists of two sections. Phase one considers the factors influencing the mental health needs of refugee youth in New Zealand. Phase two outlines the challenges that youth and their families face in accessing mental health services. In each section, participant quotations have been used to illustrate the issues raised.

PHASE ONE: FACTORS INFLUENCING MENTAL HEALTH NEEDS

Findings revealed a range of factors that influenced the mental health of refugee youth. These ranged from pre-migration stressors to post-migration and settlement challenges. The latter included discrimination, homesickness, developmental challenges, and loss of lifestyle, confidence and dignity. Each of these factors will be briefly discussed.

PRE-MIGRATION TRAUMA

Appreciating the issues and challenges faced by refugee youth presenting to mental health services in New Zealand requires an understanding of the context or conditions that may have contributed to the presentation.

As stated in part one of this report, it is necessary to consider first the pre-migration stressors that many refugee youth have been exposed to, as these have a direct impact on mental health. For example, three youths reported that they arrived in New Zealand with only their mother and siblings. Their father had either been killed or had disappeared, and the family knew nothing of his whereabouts.

Our father was taken away. We don't know where he is, or if he's still alive.

Our whole family struggle to adapt because it's hard not having our father around. He protected us and looked after us. (Youth FG – G)

With the youth who were old enough to recall their birth countries, or who had been uprooted from their country at a later age, many traumatic stories of what they had experienced were shared and reported. Stories about refugee camp life, with its daily struggle for survival, sense of disempowerment and lack of justice, and of witnessing atrocities and experiencing violence, extreme poverty and deprivation were reported by 80 per cent of youth participants.

I watched a girl being raped and I couldn't do anything because I was too scared they might do something to me. I will never forget it. (Youth FG – H)

There were many days where we didn't have anything to eat. I felt hungry a lot. We didn't have clean water. I didn't wash much. (Youth FG – E)

POST-MIGRATION AND RESETTLEMENT CHALLENGES

Participants reported that after arriving in New Zealand, adjusting to a new culture, including its language, people, religion and traditions, presented a post-migration and resettlement challenge.

The hardest thing is the social and cultural differences. It is very hard living in a Western country when you are bound by a traditional and religious family. (Youth FG – H)

My parents have struggled to pick up the language. They get frustrated with my brothers, sisters and I when we speak English, and they want us to speak our native language. (Youth FG – E)

For many youth, the issue of adjusting to a new culture was compounded by family relationships and traditional beliefs.

It is very difficult because my family is so traditional and religious. Then it is hard to do stuff. (Youth FG – F)

If we ask our parents if we could go out with our friends our parents would say no because they come from different backgrounds and they do different things. (Youth FG – E)

They have no idea what's wrong with me and I work hard at school but they don't think that, which makes me sick about my family. I am a teen that wants to get her own life. (Youth FG – H)

A mental health professional reported that:

The family was struggling with a lot of issues, and so, she was unable to communicate this with her family who were so concerned with their daily activity, such as surviving here and getting their needs met ... There was also ... some cultural conflict around her need to pursue her education from her family's perspective and her need to engage in artistic pursuits, so like the music that she was involved in. There was a clash you know between her family's expectation and her expectation around this area. (Professionals FG – C)

Discrimination

In addition to struggling with clashes between a new culture and family expectations, participants also talked of their struggle to connect with people outside of their family. Youth felt discriminated against because of their appearance and their status as refugees.

The hardest things being a refugee is they're mostly from Africa. People just know if you are refugee because of your features. (Individual interview – K)

The hardest thing being a refugee is that people expect us to fail and not be the best we can. That is why we want to prove them wrong. Some people expect you to be a bad person and they judge you before they know you. (Individual interview – I/J)

It was hard because I'm kind of dark skinned and I didn't know English so couldn't understand a thing that they were saying. But I could see by their body language that they were saying bad things. Sometimes we felt like a minority. (Individual interview – K)

Homesickness

Difficulty reconciling family and cultural differences sometimes resulted in the experience of homesickness. At least 50 per cent of the youth respondents reported that they did not recall their birth country, because they were either born in the refugee camps or grew up in the camps.

I don't have any memories of my parent's homeland. I was born in the refugee camp in Thailand, whereas my parents are from Afghanistan.
(Individual interview – I/J)

However, for those old enough to recollect their birth country, experiences of being homesick and of adjusting to the host community were another challenge.

I felt homesick two days after I came to New Zealand. Everything was different and it took a long time to get used to it. I still feel homesick and I wish to go back. (Youth FG – F)

In our village back home, I had heaps of cousins to play with, and aunties and uncles and grandparents. It's only my family here. We don't have anyone else. My parents used to worry that if we did anything wrong we would be sent back. They worried a lot about doing the right thing so that we could stay. I didn't want to live here in the beginning because I missed my friends and family back home. (Individual interview – U)

Developmental challenges

A further challenge for youth comes in the form of changes in physical development, including identity formation and search for independence.

I kept growing taller. This made it hard for the family because they had to get me new school uniforms. (Youth FG – F)

My kiwi friends were allowed to go out at night to the movies or to each other's house. I was not allowed because my parents are very strict. I used to argue a lot about this with my parents because they weren't treating me fairly. They were treating me like a little kid. (Youth FG – G)

Loss of lifestyle, confidence and dignity

In addition to those factors already discussed, there is often a significant loss of lifestyle and career for refugee youth's parents and caregivers, which, as suggested by research (Lustig, et al., 2004; Schweitzer, et al., 2006), can result in feelings of shame, confusion, loss of confidence and dignity.

Being a refugee is very different from others because our parents rely on the Government for financial support as they don't know the language and they're not educated, so they can't get a job. (Individual interview – X)

I worked hard in factory jobs because I had to look after my children. I've never been on the government benefit because it is too shameful. While I can work, I will work. I didn't work in factories in my country. Both my husband and I came from professional backgrounds. (Individual interview – P)

PHASE TWO: CHALLENGES TO ACCESSING MENTAL HEALTH SERVICES

The findings, in relation to the issues and challenges that refugee youth and their families face in accessing mental health services, have been grouped into four categories: personal and cultural, family, social and economic, and service capability. Within each of these four categories, refugee youth and their families, and health professionals raised similar and

different issues. A breakdown of the different perspectives is shown in Tables 1 and 2 below. The issues raised in both tables are presented together in the following discussion of the findings.

TABLE 1: SUMMARY OF ISSUES IDENTIFIED BY REFUGEE YOUTH AND THEIR FAMILIES

Issues and challenges	Specific elements
Personal and cultural	Language Stigma and privacy Impact on schooling and work
Family	Paucity of mental health and service knowledge
Social and economic	Lack of transport and waiting lists
Service capacity	Capacity building

TABLE 2: SUMMARY OF ISSUES IDENTIFIED BY HEALTH PROFESSIONALS

Issues and challenges	Specific elements
Family	Managing family's goals and priorities Including family in interventions
Service capability	Managing interpreter's or support person's responses Liaising with other agencies Lack of cultural knowledge and skills Engagement difficulties

PERSONAL AND CULTURAL

This category identifies and considers the challenges that refugee youth encounter, either in regard to their own knowledge and abilities, such as language, or in the form of cultural factors, such as stigma and privacy, and the impact that attending services has on schooling and work.

Language

For many refugee youth, particularly those who arrived in New Zealand over the age of 13, language posed significant challenges. These challenges occurred on a number of levels. Firstly, when interpreters were provided, this raised concerns around confidentiality, privacy and fear of judgement from the interpreter. Secondly, language posed a barrier to completing screening or assessment forms. Thirdly, and critically, was the challenge of trying to make health professionals understand, from their cultural perspective, what difficulty was going on in youth's and their families' lives.

My parents found it especially hard trying to make the doctor understand from their perspective why as a family we were struggling so much. They felt the doctor didn't understand because he was not from the same culture as us. (Youth FG – G)

Families repeatedly raised frustration as a challenge, experienced as a result of not being able to engage with a professional that could speak their language.

Even though I could speak okay with the counsellor, my parent's English is not so good, and they often got frustrated when they could not share their information. I also got frustrated because I was being used by my parents to do some interpretation and I did not want to do that. (Individual interview – W)

Frustration also occurred where there was no option of having an interpreter present. Five youths suggested that GPs needed to provide translators so that they would not have to act as interpreters for their parents. In addition, when the GP, school counsellor or psychotherapist tried to explain mental health problems, such as anxiety or depression, often there was little or no equivalent description of such conditions in the youth's homelands. If understandings of such conditions did exist, there were certainly no mental health services set up to address these problems in their homelands.

Youth and their families reported that having pamphlets in their native language about mental health and services would be particularly helpful.

It would have been helpful to have had the information about the service in my language. When I tried to use the dictionary to translate, it still did not make a lot of sense. (Individual interview – X)

These pamphlets could be displayed in places such as the family medical clinic.

Stigma and privacy

Youth and their families repeatedly discussed concerns about the stigma related to accessing or utilising a mental health service. The majority of families reported that they preferred to

access primary health organisations and school professionals to support their children with physical, behavioural and educational problems, rather than engage with mental health professionals.

Our GP has helped us with a lot of things. He even wrote a letter for us to Housing New Zealand because our house was too cold. When the children started having problems in school, we wanted the children to see the GP and not the mental health service the teacher told us to take them to. We did not want our children to attend a mental health service. What would other people in our community think of us. (Individual interview – O, mother)

At an organisational level, two of the professionals reported there are clear guidelines about letters regarding appointments and referrals being sent to family members. The name of mental health services, often clearly indicated in the letterhead, was considered an immediate social stigma and barrier to uptake of services for refugee families. Thus, stigma does not necessarily come in the form of personal contact, but may be seen in something as small, and seemingly innocuous, as a letter.

When refugee youth and family did engage, the majority of parents who participated in the study appeared supportive of possibly allowing mental health professionals to conduct the assessment and treatment in their home. This idea was, however, met with reservations by at least a third of the parents and caregivers. When queried further about their reasons for such reservations, concerns about protecting the family's privacy and lifestyle were discussed, including fear of discrimination and judgement by professionals entering the home.

We appreciated it when the social worker offered to come to our home to see our daughter. But, we have many people living in the house. It is crowded, and we were anxious about what the social worker might think about our home. (Individual interview – O, mother)

Additionally, some of these parents raised questions around what happens if other family members or friends should unexpectedly visit the family. They were worried about how they would explain both the presence and the role of the mental health professional.

A few family respondents strongly discussed their feelings of being excluded and not well supported when their sons or daughters were under a mental health service that allowed children to be interviewed separately from their families. They reported a dislike of clinicians interviewing their child in separate sessions or separate rooms from them and not inviting them to be part of the session.

Even though the family therapist sat down with us first as a family and explained that she would meet with all of us and then our daughter separately, I did not like this. When we were sitting in the other room waiting during their discussions, we felt like outsiders because we were not being included. (Individual interview – W, father)

This made them feel suspicious of the service and their intentions. They further stated that they did not like the concept that, once the youth was 16 years old, they were legally able to see the professionals themselves without having any parents or other significant family members present.

No matter how old our children get, whether they're 13, 18 or 50, we will always have a say in their life and what happens with them. We didn't like that 16 years old could see the professional without us present. Did they think we had done something wrong? (Individual interview – T, father)

The result of these feelings was that the family often disengaged quickly from the service before any intervention could occur. Yet for some refugee youth, confidentiality, with respect

to family not knowing what is discussed, is very important when accessing mental health services.

I get paranoid a lot that the stuff I talk about will be shared with others. I often ask them that it's confidential because I don't want my parents to find out. (Individual interview – N)

Impact on schooling and work

Another significant concern was the amount of time that was required for both the assessment and treatment. At least half of the parents stated that they tried to schedule appointments early in the morning before school started, or after school to minimise the impact it would have on the youth's attendance at school and on their school work.

It's important to the family that the children do not miss out too much on their schoolwork. Their education is very important. We don't want them to end up as taxi drivers or cleaners. They deserve a better life, and without doing well in school, they won't get that. (Individual interview – O, mother)

However, this approach would still have an impact on the parents' work commitments, if they were in paid work. A couple of parents discussed the strain this had had on the family's income, which increased the overall household stress. They discussed the constraints of having to provide for the rest of the family financially, in order to continue providing the basic necessities of food, shelter and clothing.

Every time I take time off work to take him to an appointment to see the doctor, or the mental health place, I can't make up that time with overtime. So I get paid less. The school counsellor said taking him to the mental health place would help him do better in school. I don't see how. I fight with my family about who's going to take time off work to take him to his appointments. (Individual interview – R, mother)

FAMILY

This category recognises that refugee youth and their family are inextricably connected. Therefore, any challenges to accessing mental health services are not just faced by the individual, but by those with whom they share a close relationship. Factors identified in this category are managing the family's goals and priorities, including the family in any interventions, and the paucity of mental health and service knowledge.

Managing family's goals and priorities

At least 80 per cent of parents or caregivers highlighted that their most important goal on arrival in New Zealand was providing for their family and meeting their basic needs. Other important goals included raising children in a warm, safe home, and supporting children to go to school when they had missed many years of formative education. Another key goal included liaising with agencies to bring loved ones and other family members to New Zealand, so that they too could be safe.

Goal setting is a key component of therapeutic work. Managing different family goals and the conflict caused by diverging goals was another common theme. As a clinical psychologist reported:

The family wants one thing and the youth wants another thing from the service. For example, the family wants the youth to attend a single sex school, while the youth wants to attend a co-ed. This is resulting in lots of arguments and fraction within the family. (Professionals focus group – D)

Extending from this statement, the psychologist stated that she felt that she spent more time and resources managing family dynamics and relationships, than she did focusing on the youth's goals. For many refugee families, their children are considered a key part of the family collective, rather than distinct units from them. When setting goals with the youth, a father reported:

No matter how old they are, they're still my child, part of my family and I got to know what's going on, and you know, and what's wrong and how to help. I can't do this if they speak to my child [17 years old] without me.
(Individual interview – K, father)

Including family in intervention

During discussions about what key issues refugee youth presented to mental health services with, worrying was a common response. The explanations given about what contributed to these worries appeared to be related to practical tasks within the youths' physical environments.

Our home is cold in winter. Our main concern is how to keep the children warm and not get so sick over the winter months. (Individual interview – T, mother)

In this instance, post-migration and resettlement challenges were a greater immediate issue, in contrast to difficulties related to any pre-migration stressors. On examining the demographics of the youth respondents, the average number of other family members living in their home was greater than five.

There are a lot of people living in the same house as us. Aunty, uncle, cousins and my brothers and sisters. You don't have any privacy and it's crowded. (Individual interview – K)

Thus in many instances, having to be responsible for younger siblings (because both parents had to work) meant youth were unable to engage in recreational or social activities. In addition, the responsibility for the younger siblings meant some were not able to engage in after-school or weekend tuition classes to help develop their learning skills.

It's hard work trying to take care of my younger brothers and sisters when I have a lot of homework from school to complete. Often I don't get it done and then I don't do so well in school. (Individual interview – T)

Therefore, a challenge to working with refugee youth is the need to involve their family or community members. One way to manage this challenge is through the use of psycho-social education.

So having an opportunity for her to speak about that stuff, you know, asking her, ... asking her about how she would like to or want to address, and then we brought in her sister into the situation and did some psycho-education around depression and self-harm stuff and the suicidal thinking which her family was not aware of. (Professional focus group – C)

Paucity of mental health and service knowledge

For at least one-third of youth and their families who participated in the study, there was a lack of knowledge about, and distrust of, mental health conditions and services. Where knowledge did exist, there were misunderstandings, and even suspicions, about the services and what they could assist the family with, as illustrated below.

We didn't know that there was a mental health service for children. When we found out, we were suspicious about it, even though they had sent out some information with the appointment letter about the service. (Individual interview – M, father)

Discussions surrounding the lack of familiarity with Western mental health ideologies were common with all the parents who participated in the study.

In our country, there's no such thing as a mental health service. (Individual interview – L)

People get inhabited by spirits that make them do things they normally don't do. We take them to the temple to get them better, we don't give them medications. (Individual interview – R, mother)

Lack of familiarity may have contributed to the engagement challenges cited by more than half of the youth and their parents. The youth who participated in this study represented a variety of ethnic and cultural backgrounds. Within these, there appeared to be common ground regarding the differences in their culture's perception of mental health conditions, versus the mental health ideologies they had experienced in New Zealand. Because of such differences, some youth discussed their family's stronger adherence to traditional mental health and treatment beliefs. This appeared to be because the ideologies were significantly different.

When I have nightmares about what happened in the refugee camps, my parents consult their friends and elders in the community about what to do. My school guidance counsellor told me I had post traumatic stress disorder. I tried to explain it to my parents, but they didn't understand. (Individual interview – U)

SOCIAL AND ECONOMIC

This category highlights the environmental challenges of accessing mental health services in New Zealand. Of particular importance are the issues of transportation and waiting lists impacting on the timing of service delivery.

Transportation and location of services

Participants in this study identified a number of barriers to accessing mental health services, as a result of traditional service delivery, including working hours of 8am to 5pm and services

being delivered from fixed locations. A number of families reported that transporting their children to the mental health services was a challenge, given that they were not in a position to own more than one vehicle. With only one vehicle available, the use of the vehicle had to be prioritised to support the family members to work, or for the family to use to attend community, religious or other functions.

The family can only afford one car. We have a lot of community and religious commitments. We sometimes could not take our child to the appointment because we had to use the car to go to the religious event. (Individual interview – L)

As well as location of services, the time taken to be seen by a service was also an issue.

Waiting lists and waiting times

While six weeks on a waiting list may appear to be a short timeframe, three of the respondents who had accessed mental health services reported that not being seen sooner led to them experiencing more challenges in their life.

When our family received the appointment letter, the earliest appointment they could give was nearly two months away. We needed our son to be seen immediately because he was not sleeping and doing things that were not normal for him. His behaviour got worst and he started to hit out at the family. We took him to A & E because we were desperate and didn't know what to do. (Individual interview – R, mother)

Often the time a refugee youth has to wait to see a professional can diminish their interest in utilising mental health services.

They can like make my appointment on time. Sometimes I go at 10 and I had to wait till 11. Once I waited over two hours. It annoys me, waste my time. (Individual interview – N)

Sometimes the issue of time is not about having to wait, but about being rushed into making a decision and accessing services. One family discussed resentment when they felt “pressured” by their child’s school, or other professionals such as their GP, to take their child or children for help because of their “mental health” problem. The family reported they had other major “practical” problems, such as providing for the family.

For us as a family, our children are important. Their happiness is important, but it has not been easy finding work and earning money to look after them. We have many children in the family, and looking after their basic needs is more important than finding time to take one of the kids to a mental health service. (Individual interview – T, father)

SERVICE CAPABILITY

This category presents findings related specifically to service delivery, such as managing interpreters’ and support people’s responses, liaising with other agencies, and capacity building. It also includes findings about service knowledge, including lack of cultural knowledge and skills, and engagement difficulties. These factors represent further challenges to accessing mental health services for refugee youth.

Managing interpreters’ and support people’s responses

In engagement, assessment or treatment with refugee youth and their families, interpreters and support people may be called upon to assist youth and their families. This will depend on youth’s and their families’ language skills, self-confidence, support and degree of acculturation. Using interpreters or support people can, however, present a number of issues. These include the change in dynamics within the sessions from that of a dyad to a triangular relationship. The triad can impact on both rapport and transference.

In addition, there is the issue of matching the interpreter with the client with respect to gender, ethnicity and language competency. Furthermore, consideration must be had to pre-interview briefing and debriefing by the interviewer, in situations where the interpreters may themselves experience distress. This last issue was raised during a group discussion.

After one of the sessions with the family, I spent another hour counselling the interpreter who had been re-traumatised by the client's story. I hadn't scheduled that into my day and had to cancel another appointment.
(Professionals focus group – A)

In regard to challenges with a support person, one respondent stated:

While the parents may have found the support person from refugee services helpful, I felt that the young person may have hesitated to share her story about what was contributing to her poor school work at school, and I wonder what's the impact of sharing the story with not one, but two other persons whom you don't know very well. (Professionals focus group – A)

Liaising with other agencies

Where multidisciplinary, multi-ethnic and culturally competent teams are not possible, multiple agency coordination and collaboration needs to be considered. At times multi-agency coordination may require a change within the service environment and to the traditional roles of the multidisciplinary team. One example of this is seen in the role of advocating.

Since our parents have been in New Zealand the GP and counsellor have helped a lot, for example, the guidance counsellor has been to one of our family court cases. The GP has helped by writing letters to the people involved with our problems. They've helped us because we hardly knew

anyone in New Zealand and they made us more confident in a developed country. (Individual interview – I/J)

At other times, multiple agency coordination involves two or more agencies actively working together. The challenges related to liaising with other agencies and professionals that are involved with the refugee youth and their family was a recurring theme with all professional respondents.

CYFS had their own goals for the family. It wasn't always easy getting hold of the child's social worker. Ended up having a meeting with the social worker's manager and our service manager had to get involved. (Professionals focus group – A)

When I finally saw the girl and her family, the reasons why she was referred for in the first place from the other agency was not the real problem for the family. I called the referrer who asked me whether I had my own concerns about sexual abuse. What the heck, nothing had been stated in the referral about that, and again, this didn't seem to be the youth's or the youth's family's key concern. (Professionals focus group – A)

Despite the known difficulties associated with multiple agency collaboration, services need to remain open to this way of working.

Capacity building

Capacity building, rather than the direct provision of services by mental health professionals, should be an intervention priority in all communities. Hence, intervention needs to be integrated into community settings and activities, for example schools, community centres or people's homes. This is especially important in refugee communities that under-utilise, or have limited access to, professional mental health services, and may help enhance

participation and the long-term sustainability of the interventions, as well as empowering people to have greater control over the resources that affect their lives.

When a small number of people from their ethnic community had already been settled in New Zealand, this appeared to be a positive protective factor for youths' mental health.

It really helped my family and I to have people here from our own country to show us to work with housing New Zealand and WINZ. I felt that my parents found it easier to ask for help from people of similar culture than from someone who wasn't. (Youth FG – E)

Additionally, having host community support was integral. In New Zealand, sponsoring refugees, whereby individuals or families would volunteer to help set up newly arrived refugees, is a common practice. These volunteering acts of kindness were reported to have a huge positive impact on how some families coped.

Our sponsor's family helped us to find a job and put our children into a good school. She also helped us to find a good home for us. Without the sponsor's assistance I think it would have been harder for my family to learn to live in New Zealand. At the time there were not many people around from my own country. (Individual interview – T, father)

The peers that adolescents associate with can act as both a positive and negative moderator to how they cope with life stressors. Many of the youth talked about their friendships and the positive impact this had in their life.

When I'm angry or sad, I call my friends. It's easier to talk to my friends than to my family sometimes. My friends are always there for me. (Individual interview – T)

Lack of cultural knowledge and skills

At least half the professional respondents reported that they felt they did not have the appropriate cultural knowledge and skills to work with refugee youth and their families. Professionals were fearful of insulting refugee youth and their families, because of this awareness of their limited understanding of the client's customs and cultural practices.

It's like, I know I'm lacking in understanding of the kid's background, but I don't always know who to go to. I would like more training on how to work with refugee youth and their family who present with mental health problems. (Professionals focus group – D)

Professional respondents also discussed the lack of cultural support workers available to assist them in their work with youth from refugee backgrounds, and the impact this had on their work, from struggling to engage the family, to conducting any form of assessment or treatment that would be of use or benefit to the family.

At our workplace, there's no cultural support worker or the equivalent of a Maori or Pacific elder to help provide cultural consultation and support for our work with refugee families. I feel like I'm working in the dark sometimes, and I wonder why treatment efficacy has been so poor with the work I have done with refugee youth to date. (Professionals focus group – A)

We're required to attend the Treaty of Waitangi training when we start at our workplace. However, there's been no support for training to work with people from other ethnicity and culture. (Professionals focus group – A)

The lack of culturally competent staff may impact upon youth's willingness to engage in intervention if their needs are not recognised. For example, a number of the families raised

challenges caused by having limited access to gender appropriate professionals, especially for families with Muslim beliefs. Depending on the age of the youth, this was either more or less of an issue. For example, youth aged between 13 to 15 years did not report the desire to access professionals of the same gender. However, older youth did express a greater need to engage with professionals of the same gender. This appeared to be particularly significant for the female youth respondents.

When I saw the psychologist, I really wanted to see a female one because of what I had experienced back home. I didn't feel comfortable about talking to a male. My parents would also have not felt comfortable about me speaking to a male without them present. (Individual interview – X)

If staff are not culturally aware of issues, such as gender matching, service intervention is likely to break down.

Engagement difficulties

Before any assessment or treatment can be completed with youth and their families, the professional, or the service the professional works for, must first engage youth and their families at multiple levels. A recurring theme, which at least 75 per cent of the health professionals discussed, was difficulty with engagement. The quotations below highlight the attempts made to contact and engage the family through telephone calls, appointment letters, and the support of an interpreter and a volunteer from refugee services.

I contacted the family by phone first, but despite three attempts, I could not make contact. I then sent out an appointment letter, but the family DNA. I then engaged a volunteer from refugee services and an interpreter. They helped to arrange an appointment. The family however still DNA. It's frustrating. (Professionals focus group – A)

After two missed appointments from the family, I took a colleague with me to do a home visit to see if everything was ok. I knocked on the door, but no one opened the door. I left a note to say I had visited. They never came back for any further appointments. I'm not sure what happened to the youth or their family. (Professionals focus group – A)

The GPs and school guidance counsellors reported engagement and support challenges with the families of refugee youth as a whole. This was despite the youth being their primary client. One school nurse reported that:

[x] had been coming to visit me almost every second day with some sort of headache or stomach ache. She slowly began opening up about her home life and how she was struggling with her step siblings. I tried calling the family because she was growing sadder by the day, but the family struggled with English and I just ... I just couldn't get them on board to help the girl. (Professionals focus group – D)

The professionals further expressed a desire to either learn, or have access to individuals who would be able to teach them, about basic cultural practices of particular refugee communities, in order to:

- assist them with engaging the family
- respect the family's culture as much as possible
- identify cultural assumptions and practices that could enhance the assessment or treatment outcomes.

LIMITATIONS OF THE STUDY

The following limitations to the study are acknowledged.

- A greater proportion of professionals from specialised mental health services participated in the study than professionals from primary health organisations.

However, youth and their families reported that they felt more comfortable accessing primary health and education organisations to get support for mental health concerns. This may have affected the nature of the data collected from youth and their families.

- Significant difficulties were encountered in engaging refugee youth to discuss their experiences of mental health services. As a result, fewer youth than were aimed for participated in the study. While the sample size can affect the generalisability of the research, the qualitative nature of the research still provides a rich account to help inform service development.
- This study lacks detailed analysis of the assessment and treatment conducted with refugee youth. This would have provided greater understanding and aided development of these key skills with professionals, to increase treatment efficacy and outcomes with refugee youth.

PART TWO: SUMMARY

To answer the question ‘What is the nature of the issues and challenges faced by refugee youth when using mental health services in New Zealand?’, focus groups and individual interviews were held with refugee youth and their families and with health professionals. Part two has presented the findings of this data, using participants’ words where possible to illuminate the issues being discussed.

From the data, two key findings were revealed: factors influencing mental health, and challenges to accessing mental health services. For refugee youth, the key factors influencing their mental health were pre-migration trauma, and post-migration and resettlement challenges, including homesickness, developmental challenges, discrimination, and loss of lifestyle, confidence and dignity. Each of these factors is critical and points to the wide range of skills and resources that mental health services need to consider and address when working with refugee youth.

However, the findings reveal that refugee youth experience multiple challenges to accessing mental health services. These challenges have been grouped into four key categories: personal and cultural, family, social and economic, and service capacity. Within each of these categories, refugee youth and their families, and the health professionals identified different issues of concern. For instance, from a refugee youth and family perspective, a challenge to accessing services involved notions of privacy and parents wanting to be involved in interventions. For health professionals, however, there was a need to protect the privacy of the youth, which created tensions to do with including family. There were some points of agreement, particularly with regards to service capacity, and the cultural barriers that exist as a result of differing perspectives on mental health issues and language.

LET'S GET REAL AND REAL SKILLS PLUS CAMHS

Let's get real provides a service-user-centred approach to develop the essential knowledge, skills and attitudes needed to deliver effective mental health and addiction services. Developed by the Ministry of Health, *Let's get real* identifies seven Real Skills that everyone working in mental health and addiction is expected to demonstrate, regardless of their role or occupation, or organisation they work in. Practitioners can use this framework to inform their professional development.

Real Skills Plus CAMHS is a competency framework developed by the Werry Centre for Child and Adolescent Mental Health Workforce Development. It describes the knowledge, skills and attitudes that a practitioner needs in order to work with infants, children and young people who have moderate to severe mental health, or alcohol or other drug, difficulties, and their families/whānau and community.

Let's get real identifies being open-minded and non-judgemental as necessary attitudes of every person working in mental health and addiction. The fundamental values include respect, service, recovery, positive relationships and communities. *Let's get real* values and attitudes need to be demonstrated by all people working in mental health and addiction. These are particularly crucial when working with refugee youth. For example, discrimination is identified as a post-migration factor and settlement challenge that influences the mental health of refugee youth. Thus creating services in which refugee youth feel safe and respected is important.

One of the seven Real Skills highlighted in this report is Working with service users. This Real Skill identifies the need for every person working in mental health and addiction treatment to use strategies to engage meaningfully, and work in partnership with, service users, and to focus on service users' strengths to support recovery. Performance indicators recognise the need to use age-appropriate and culturally appropriate protocols and processes when working with service users. The report supports the need for this Real Skill. For example, it examines

how common developmental challenges are compounded by the personal and cultural challenges that refugee youth face. The stigma associated with accessing or using a mental health service means service providers need to look for ways of providing services in culturally appropriate ways.

The report describes the negative impact that stigma and discrimination have on the mental health of refugee youth. The *Let's get real* Challenging stigma and discrimination Real Skill endorses the need for every person working in mental health and addiction to understand the impact of stigma and discrimination on service users, families/whānau, services and communities. Practitioners are encouraged to use strategies to reduce stigma and discrimination, including promoting and facilitating social inclusion.

This Real Skill states that it is essential to understand, and work to mitigate, the physical, social and emotional effects of trauma and abuse on people's lives. The report identifies pre-migration trauma as a key factor influencing the mental health of refugee youth. Practitioners who are working with refugee youth thus need to practice the principles of trauma-informed care.

The report recognises that refugee youth and their families/whānau are inextricably connected. For example, it highlights the need to involve family or community members in mental health interventions with refugee youth. *Let's get real* and Real Skills Plus CAMHS both identify the ability to work with families/whānau as an essential key competency. *Let's get real* states that every person working in mental health and addiction needs to encourage and support families/whānau to participate in the recovery of service users. This is reinforced by Real Skills Plus CAMHS, which states that families/whānau need to be involved at all points of the young person's contact with the service, where appropriate.

The *Therapies for Refugees, Asylum Seekers and New Migrants: Best and promising practice guide for mental health and addiction services* (Te Pou, 2010) has been developed to support

the aims of LGR. The resource includes best and promising practice approaches for working therapeutically with refugees, asylum seekers and new migrant service users.

CONCLUSION

This project examined the issues and challenges experienced by refugee youth when accessing mental health services, and used this to consider how cultural responsiveness could be improved.

The entry point for working with refugee youth and their family is effective engagement. As stated in the findings, engagement difficulties were an issue identified by health professionals, which impacted on service capability and the provision of appropriate interventions. Yet engagement remains critical for ensuring a solid relationship, upon which interventions to assist refugee youth with their mental health issues can occur.

A fuller understanding of a client's problems and their perspective contributes to a greater likelihood of obtaining an accurate assessment of the problems (Norfolk, Birdi, & Patterson, 2009). A number of the professional respondents believed that it is the connection and the therapeutic relationship that supports youth and their families with the recovery process.

Increasing the number of multicultural and multi-ethnic mental health workers would help to decrease engagement difficulties between families and services. The following additional strategies may assist professionals and services to develop better engagement and rapport with refugee youth and their families.

- 1) Meet with a cultural support worker to develop an understanding of the context that the refugee young person may have come from, including what cultural practices and beliefs are critical when engaging or working with refugees from that particular ethnic or cultural background.
- 2) Work with the cultural support worker to engage the family. It may be more helpful to have the cultural support worker make the first call to the family to arrange a time

and place to meet for the first appointment (perhaps the family's home or community centre).

- 3) If required, arrange an interpreter for the family. Do not use youth to interpret for other family members, as this places youth in a difficult position and raises a number of issues, such as challenging the family's role hierarchy.
- 4) Allow more than a couple of weeks or sessions to conduct a full mental health assessment with the family. Time and permission must be allowed for engagement, assessment and treatment with refugee youth and their families, which may take longer due to language, cultural, family and other factors.
- 5) If the family offers refreshments during the first or subsequent session, accepting the food helps develop trust and respect.

Better adherence to interventions, or a greater willingness to attempt interventions, may occur when professionals feel a genuine sense of reciprocal rapport with youth and their families, as a result of effective engagement. Professionals stated that families kept attending sessions where the clinician felt that they had helped to assist the family to stabilise within the new environment. They also stated that families were more likely to adhere to a combined intervention approach, which incorporated traditional beliefs about treatment for the condition from their country. An example might be supporting families to conduct ceremonies to speak, or make sacrificial meal offerings, to evil spirits causing harm to the family. In addition, professionals who were willing to engage the family in a neutral space, such as a room in a community hall or in the person's home, reported that families more readily participated in treatment sessions. These points reflect the need for professionals and services to be flexible in their approach to working with refugee youth.

Screening and screening instruments help identify interventions that might best meet the needs of refugee youth. However, professional respondents were unable to identify assessment and screening tools or instruments developed with ethnic youth populations. It is

critical that individuals responsible for screening clients at services have a greater awareness of the possible conditions that refugee youth may have been exposed to.

Many professionals discussed service constraints, such as lack of cultural knowledge and skills, in their practice with refugee youth and their families. This led to other challenges when trying to assess the youth's and their family's mental health concerns, for example, having a limited formulation of the youth's problems. Professionals also reported that the questionnaire often used during assessment with youth did not support the engagement process. The questionnaire or assessment form provided little support or clarity in identifying key challenges for youth and their families. The following table presents a list of questions that refugee youth and their families have suggested would be helpful to ask.

TABLE 3: QUESTIONS IDENTIFIED BY REFUGEE YOUTH AND THEIR FAMILIES

Questions
1. What is the youth's or family's understanding of why they are being seen?
2. What is their understanding about the service that they are seeing?
3. What are their expectations about the service, and what do they think or hope the service can help them with?
4. What are the key challenges the young person and their family continue to face since being in New Zealand?
5. From the challenges discussed, what is the young person's or family's primary concerns?
6. What does the family think is causing or contributing to the problems that the young person or family is experiencing?
7. What does the family think needs to occur to make things better?
8. Traditionally, if a similar problem occurred back in their home country, how would the family deal with the problem?

Local values and beliefs regarding psychological wellbeing and distress should be incorporated into the design, implementation and evaluation of any intervention (Miller &

Rasco, 2004). Aspects of culturally appropriate concepts that were raised in this study related to privacy issues and to a lack of familiarity with Western mental health beliefs.

Interventions should address the problems that are of concern to youth and their families or community members. Examples of themes illustrated in this study were family discord and poverty-related stressors, such as inadequate housing and employment difficulties. A recurring theme with all professional respondents was challenges in liaising with other agencies and professionals that were involved with refugee youth and their families. This can present a significant barrier to supporting youth and their families in the recovery process, when the agencies' goals and agendas for the youth are incongruent with one another. Working alongside families, to ascertain their level of knowledge and understanding of the services being provided, is fundamental to addressing the mental health needs of refugee youth.

In conclusion, refugee youth and their families have unique background experiences, beliefs and may experience practical challenges in accessing services. These need to be considered when addressing the mental health concerns of refugee youth. The report has identified practical strategies for responding to the needs of this group. Information provided can support services to work with and respond effectively to refugee youth and their families

APPENDIX A: DESIGN AND METHOD

RESEARCH DESIGN

This research was exploratory in nature and used qualitative research techniques. The study employed a multi-phase design: phase one involved focus group discussions, and phase two individual face-to-face interviews. In both phases, demographic data, such as gender, ethnicity, and duration of residence in New Zealand was gathered to supplement the qualitative data.

ETHICS APPROVAL

The study was approved by the University of Auckland Human Participants Ethics Committee in November 2008 (Reference 2008/369). The following ethical issues were addressed in relation to this project.

- Seeking informed and voluntary consent – participants were provided with verbal and written information prior to commencement of the study, and written consent was obtained to participate in the project. Participation was voluntary and participants had the right to not answer questions, or to stop the interview process at any stage. In addition, participants were informed they could withdraw from the study at any point in the process.
- Respect for privacy and confidentiality – research participants were given clear and accurate information about the project, in a way that did not risk their safety and security. Written consent was arranged, with an explanation on the importance of protecting the identity of the participants. Data and transcripts of the study entered in the computer were given a number coding, thus removing any identifying participant details.
- Avoiding cultural harm – the principal investigator was born overseas and immigrated to New Zealand with her family as a refugee in 1986. She is an active member of community activities and is mindful of the cultural sensitivities of a range of ethnic communities. Furthermore, cultural advisors based at the Refugees as

Survivors New Zealand service were used to minimise and avoid cultural harm to the participants.

- Protecting confidentiality in focus groups – it is almost impossible to ensure absolute confidentiality in focus groups, as participants may choose to talk about their experiences and express their opinions on topics covered in a group discussion. However, clear rules (for example, the need to respect each other's opinion and to not talk about the materials covered in the meeting outside the group) were explained fully and reinforced during the group process.

Documentation about the study, for example the project information sheet and consent forms, is available upon request.

RECRUITMENT STRATEGIES

Fifteen organisations were contacted and sent an introductory letter and information sheet regarding the study. The organisations were asked to disseminate the introductory letter to their employees who have worked with refugee youth and their families, or to service users accessing their service. Contact details were provided on the introductory letter for professionals, youth and their families who were interested in participating in the study.

The organisations and individuals contacted included:

- 1) Counties Manukau District Health Board's Whirinaki (Children and Adolescent Mental Health Service)
- 2) Auckland District Health Board's Kauri Centre (Children and Adolescent Mental Health Service)
- 3) Waitemata District Health Board
- 4) Refugee services in both Auckland and Hamilton
- 5) Auckland Refugee Coalition
- 6) Auckland Refugee Council Incorporated
- 7) Changemakers refugee forum

- 8) Ministry of Education
- 9) Mixit
- 10) the refugee coordinator at the Auckland Regional Chamber of Commerce
- 11) Ministry of Youth
- 12) the refugee coordinator for secondary schools in Auckland
- 13) the chairman of the Somali Federation Community Inc
- 14) Auckland District Health Board Cultural Interest Group
- 15) general practice clinics in Otahuhu, Mangere, Mt Roskill and Mt Albert.

Several meetings were conducted with community link facilitators working with Refugees as Survivors New Zealand to gain feedback about the purpose and processes of the project, and to request assistance with dissemination of information to their community. This strategy was undertaken so that participation could occur on a voluntary basis.

Te Pou further assisted the recruitment phase by emailing an advertisement about the project out to its network.

METHODS AND DATA COLLECTION PROCEDURES

Phase one

Phase one consisted of two groups of focus group discussions. The first group consisted of four focus group discussions with 20 mental health and community professionals within the greater Auckland region who have worked with refugee youth. Each focus group consisted of approximately four or five participants (see Table 4 for focus group participants). The discussions focused on participants' experience of working with refugee youth. They also explored what assessments and interventions were conducted with families and how they did this.

TABLE 4: MENTAL HEALTH AND COMMUNITY PROFESSIONALS FOCUS GROUP PARTICIPANTS

Professional	Gender		Average years' experience
	Male	Female	

Psychologist	2	6	7
Social worker	1	2	10
School guidance counsellor	1	5	8
General practitioner	3		15
Total	7	13	

The second group consisted of 20 refugee youth, and their caregivers or parents, who are currently accessing, or have accessed, mental health services within New Zealand. Four focus groups, consisting of approximately four to five participants each, were conducted. Discussions focused on their experience of mental health services within New Zealand.

Youth aged between 13 to 15 years were grouped separately from youth aged 16 to 18 years. This was done for a number of reasons. First, youth aged between 13 to 15 years are navigating a different emotional and cognitive developmental phase to those between 16 to 18 years old. There were concerns that younger youth may thus not be at a developmental phase where they would be able to process some of the discussions and issues that might be raised by older youth. Second, separating focus groups by age also helped minimise the exposure of the younger youth to traumatic discourses that may be raised by older youth who may have experienced greater pre-migration traumas. Furthermore, the level of emotional maturity between the two different age groups may have inhibited open and honest communication if the two age groups were placed together.

For some ethnic groups, such as Somali, the youth were further separated into gender groups, because of cultural attitudes about gender associations, as reported by the community.

Phase two

Phase two involved individual face-to-face interviews with refugee youth. Following the focus group discussions, 16 additional youth respondents participated in individual face-to-face

interviews to provide in-depth knowledge about their experiences. Questions for these interviews were developed from key themes, which had been identified from the focus group discussions conducted with both the professionals, and the youth and their families or caregivers. Table 5 shows the ethnicities of the 36 refugee youth who participated in the focus groups and individual interviews.

TABLE 5: REFUGEE YOUTH PARTICIPANTS

Ethnic group	Male	Female
Somali	2	8
Afghan	1	4
Iraq		1
Egyptian		1
Burmese		4
Pakistani		1
Laotian	2	2
Vietnamese		5
Cambodian	1	4
Total	6	30

DATA ANALYSIS

Grounded theory methods, as articulated by Strauss and Corbin (1998), were employed for data analysis. In particular, the first two stages of coding (described as open and axial coding) were used. Open coding essentially involves selecting and naming categories for analysis. During open coding, the researcher looked for features that described the phenomenon being studied. The themes were labelled, identified, categorised and related to one another. Following this, axial coding occurred, whereby it was attempted to put the data together in new ways. The key task involved making connections between the sub-categories and categories, and involving paradigm models that tried to explain or make sense of the relationships between categories.

Focus group discussions with the community and health professionals were audio taped and transcribed as early as possible to support early familiarisation with the data. Transcripts, including notes from the interviews, were read and reread, and initial coding of data commenced. Data relevant to each code was collected. This, together with feedback from the cultural advisory group, was used to develop questions for the in-depth, one-to-one interviews with the youth (in phase two). Concepts from the second phase were also recorded and coded.

The third part of the analysis involved collating the codes from both phases into potential themes. Again, data relevant to each potential theme was collected.

When the linked categories and core categories that had been identified appeared repeatedly in new data, this indicated that data saturation had been reached. Coding continued until theoretical concepts capturing the youths', families' and professionals' perspectives linked together. Memos were written throughout the research process about the different codes and themes, and these memos were grouped together for similarity of ideas, for example, engagement challenges.

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